

6-11-1997

DDASaccident230

Humanitarian Demining Accident and Incident Database
AID

Follow this and additional works at: <https://commons.lib.jmu.edu/cisr-globalcwd>

 Part of the [Defense and Security Studies Commons](#), [Peace and Conflict Studies Commons](#), [Public Policy Commons](#), and the [Social Policy Commons](#)

Recommended Citation

Database, Humanitarian Demining Accident and Incident, "DDASaccident230" (1997). *Global CWD Repository*. 430.
<https://commons.lib.jmu.edu/cisr-globalcwd/430>

This Other is brought to you for free and open access by the Center for International Stabilization and Recovery at JMU Scholarly Commons. It has been accepted for inclusion in Global CWD Repository by an authorized administrator of JMU Scholarly Commons. For more information, please contact dc_admin@jmu.edu.

DDAS Accident Report

Accident details

Report date: 18/05/2006	Accident number: 230
Accident time: 10:45	Accident Date: 11/06/1997
Where it occurred: Vidovice, Posavina	Country: Bosnia Herzegovina
Primary cause: Management/control inadequacy (?)	Secondary cause: Inadequate training (?)
Class: Survey accident	Date of main report: [No date recorded]
ID original source: Incident no.530	Name of source: other
Organisation: Name removed	
Mine/device: PROM-1 AP Bfrag	Ground condition: not recorded
Date record created: 17/02/2004	Date last modified: 17/02/2004
No of victims: 3	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system: GR: CQ 088850	Coordinates fixed by:
Map east: CQ196831	Map north:
Map scale:	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inadequate investigation (?)

safety distances ignored (?)

no independent investigation available (?)

inadequate training (?)

Accident report

Details of this accident were discovered in a document entitled "Synopsis of EA Military demining accidents 1997". The victims were DoS trained members of FWF/HVO engaged in "mine-lifting"..

As part of the Peace Accord, the three active armies were required to engage in humanitarian demining. They did this without keeping the country MAC informed of their working methods or giving them access to conduct accident investigations.

The document stated that two teams were due to begin demining in adjacent mined areas at Grid reference CQ 088 850. The team commanders held records of the mined area and had a discussion about the accuracy of those records. One of them said the records were inaccurate but that he knew where the mines were. He led two of his men to show them where the mines were.

At 10:45 one of the three men surveying the area activated a PROM-1.

"Although they were wearing protective equipment, they were so close to the mine that two of them were killed and one was very badly injured."

Victim Report

Victim number: 298	Name: Name removed
Age:	Gender: Male
Status: supervisory	Fit for work: DECEASED
Compensation: not made available	Time to hospital: not recorded
Protection issued: Various	Protection used: not recorded

Summary of injuries:

FATAL

COMMENT

No medical report was made available. The victim was recorded as having been killed immediately.

Victim Report

Victim number: 299	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: DECEASED
Compensation: not made available	Time to hospital: not recorded
Protection issued: Various	Protection used: not recorded

Summary of injuries:

FATAL

COMMENT

No medical report was made available. The victim was recorded as having been killed immediately.

Victim Report

Victim number: 300	Name: Name removed
Age:	Gender: Male
Status: deminer	Fit for work: not known
Compensation: not made available	Time to hospital: not recorded
Protection issued: Various	Protection used: not recorded

Summary of injuries:

COMMENT

No medical report was made available. The victim's injuries were described as "severe".

Analysis

The primary cause of this accident is listed as a *"Management/control inadequacy"* because a Team Commander made a management decision regarding field survey that caused the accident. It seems likely that he had not been appropriately trained to err on the side of caution, so the secondary cause is listed as *"Inadequate training"*.

The fact that the control group allowed the victims to be close together in a dangerous area represents a further failing of management.